

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-2762.M5

MDR Tracking Number: M5-04-2235-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 22, 2004.

Correspondence submitted by Rehab 2112 revealed Neicey Adams desires to withdrawal the fee issues. Therefore no further action is required for CPT codes 97545-WH-AP, 97456-WH-AP and 97750-FC rendered on 6/10/03 through 6/16/03, and 7/8/03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening, and functional capacity evaluation were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. As the work hardening, and the functional capacity evaluation were not found to be medically necessary, reimbursement for dates of service rendered 6/18/03 through 6/26/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

May 25, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2235-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. ____:

____ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: correspondence, office visit notes, daily treatment notes, physical therapy notes, FCE, radiology reports and designated doctor exam.

Information provided by Respondent: correspondence, ER report, radiology report and designated doctor report.

Information provided by other provider: correspondence, office visit notes, daily treatment notes, physical therapy notes, FCE, radiology reports and designated doctor exam.

Clinical History:

Patient received physical medicine treatments and chiropractic manipulation after sustaining injury while at work on ____.

Disputed Services:

Work hardening program and FCE during the period of 06/18/03 through 06/26/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the work hardening program and FCE in dispute were not medically necessary in this case.

Rationale:

A sprain/strain injury of this type could have been expected to be resolved within 8 weeks and that no further care would be medically necessary after that time. More importantly, the treatment in question did not meet the statutory standard for being medically necessary since it did not relieve or cure the effects of the injury, promote recovery or enhance the employee's ability to return to or retain employment. For documentation of that fact, the patient's pain rating was "6" on 06/18/03 at the initiation of the care, and remained at "6" after the care in question was completed on 06/27/03. Therefore, the specified treatment and examination was neither indicated nor medically necessary.

Sincerely,